

Let's talk about



safety!

The 2014 hospital National Patient Safety Goals

Master the seven goals for hospitals,
including the new clinical alarm
safety objective.

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Each year thousands of patients lose their lives as a direct result of preventable medical events, such as a hospital-associated infections (HAIs), surgical mistakes, and sentinel events that occur while patient alarms are silenced.

Mortality is four times higher in hospitalized patients who acquire an HAI, and recent research studies have found that up to 25.8% of all ICU patients will develop an HAI. This dramatically increases healthcare costs because length of stay increases from an average of 8.1 days to 15.8 days for a patient with an HAI.

We must remain vigilant in eradicating all preventable occurrences that negatively impact our patients and work to improve patient safety and outcomes.

Goal development

The Joint Commission developed the first set of National Patient Safety Goals (NPSGs) in 2002, with implementation in January 2003. Along with the goal of eliminating wrong patient, wrong site, wrong procedure surgery, the first set of NPSGs included improving:

- the accuracy of patient identification
- communication between caregivers
- the safety of infusion pumps
- the safety of high-alert medications
- the effectiveness of clinical alarm systems.

Several of the original NPSGs continue to be utilized because they address core problems that we're actively trying to eliminate. The common theme is to reduce the risk of injury to the patient and improve clinical outcomes.



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Matching goals to facilities

The Joint Commission has specific goals for the following healthcare facilities:

- ambulatory care
- behavioral care
- hospitals
- critical access hospitals
- home care
- lab services
- nursing care
- long-term care
- office-based surgery.

Each type of healthcare facility has a unique combination of NPSGs; however, the key is to note that these goals are aimed at preventable errors—mistakes that we have the ability to change.

2014 hospital NPSGs

The 2014 NPSGs for hospitals include:

- improve the accuracy of patient identification
- improve the effectiveness of communication among caregivers
- improve the safety of using medications
- reduce the harm associated with clinical alarm systems
- reduce the risk of HAIs
- identify safety risks inherent in the hospital's patient population
- prevent wrong site, wrong procedure.

Let's take a closer look.



The seven golden goals

Goal 1: Improve the accuracy of patient identification.

Improving patient identification is vital to overall patient safety. Mistakes in patient

identification can lead to errors in medication administration, failure to treat a serious illness or disease, medical treatment for erroneous diagnostic lab results, incompatible blood transfusion reactions, infants being discharged to the wrong families, and procedures being performed on the wrong patient.

To minimize the continued prevalence of patient misidentification, consider these risk reduction strategies:

- Use at least two patient identifiers when admitting, transferring, or discharging a patient; administering medications; collecting blood or fluid samples; and before performing procedures. For example, use the patient's name, date of birth, medical record number, or photograph. Don't utilize a room number as a patient identifier.
- All lab specimens should be labeled in the presence of the patient to minimize the risk of mislabeling a specimen with the wrong patient's information. Follow your facility's protocols for signing off on labs, labeling lab specimens, and identifying special labs such as type and screen for transfusions.
- Utilize new technology such as a USB palm scanner to verify the identity of patients. This device scans the patterns of veins located in the palm of the patient's hand to authenticate his or her identity. A palm scanner is an accurate way to verify a patient's identity because each individual's veins are as unique as a fingerprint. The scanner matches each palm signature with the electronic health record (EHR). One of the benefits of using a palm scanner is that the patient doesn't have to place his or her hand in contact with the scanning device. Palm scanners are also beneficial for quickly identifying patients who are incapacitated, comatose, or unable to communicate their identity to healthcare personnel. Many researchers are predicting that computer passwords may

2014 hospital NPSGs

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become unnecessary in the near future as more hospitals are adding palm scanners to identify employees, as well as patients. Another benefit of this new technology is that hospitals are utilizing palm scanners to prevent insurance fraud and reduce both clerical and medical mistakes.

Goal 2: Improve the effectiveness of communication among caregivers.

In any given healthcare organization, there are thousands of daily interactions between healthcare workers, patients, and the community. The quality of these interactions is a key component of error prevention, patient comprehension and adherence, and outcomes control.

Consider these tips to maximize communication:

- Utilize a standardized protocol for processing physician telephone orders, including clarifying the order by reading it back to the ordering healthcare team member in its entirety. Don't use telephone orders except in cases of emergency.
- Standardize processes for "read back" of critical and/or abnormal diagnostic results.
- Participate in rounding. Each healthcare team member needs to understand the patient problem list, reason for admission, discharge barriers, education needs, and progress toward meeting discharge goals. Direct communication during rounds promotes one-to-one interaction between caregivers, patients, and families.
- Participate in bedside reporting to decrease the risk of miscommunication or failing to communicate vital and pertinent information between oncoming and offgoing nurses.
- Healthcare team members who write orders should utilize a computerized provider order entry (CPOE) system if possible.
- Utilize the EHR to reduce the incidence of errors in data dissemination.

did you know?

The Joint Commission has stated that by January 1, 2016, all healthcare facilities utilizing clinical patient alarms must formulate a policy that includes:

- clinically appropriate settings for alarm signals
- when alarm signals can be disabled
- when alarm parameters can be changed
- who in the organization has the authority to set alarm parameters
- who in the organization has the authority to change alarm parameters
- who in the organization has the authority to set alarm parameters to "off"
- monitoring and responding to alarm signals
- checking individual alarm signals for accurate settings, proper operation, and detectability.

Source: The Joint Commission. National Patient Safety Goals effective January 1, 2014. http://www.jointcommission.org/assets/1/6/HAP_NPSG_Chapter_2014.pdf.

Goal 3: Improve the safety of using medications.

Errors in medication administration remain prevalent in facilities nationwide. These errors are difficult to track due to reporting failures and data collection variations. The results are often reflective of systems and not national trends. These errors include poor medication reconciliation practices; failure to provide proper patient identification; wrong dose, wrong drug errors; and look-alike, sound-alike errors.

Consider the following evidence-based interventions to reduce the incidence of medication errors and subsequent sentinel events or near misses:

- Require verification of designated high-risk medications, such as insulin, heparin, blood products, total parenteral nutrition, and I.V. vasopressors, by two licensed nurses.
- Use two patient identifiers to validate the correct patient identity before administration of any medication.
- Perform medication reconciliation verifying the patient's medications and dosages to ensure that his or her current medication regimen is correct.

- Utilize electronic medication dispensing units to track medication dosages and frequency.
- Educate all healthcare team members about the danger of common trends that can increase the likelihood of medication errors, such as using unapproved abbreviations for medication names, dosages, routes, or frequency.
- Use “tall man” lettering for potential look-alike, sound-alike medications.
- If you’re required to mix a medication, label the medication or solution as soon as it’s prepared, including the medication name, strength, quantity, diluent, volume, and expiration date.
- When administering medications to pediatric patients, prefilled syringe products should be used only if specifically designed for children.
- When administering medications to a patient in a shared room, review the medication administration record (MAR) before administration. In a recent study evaluating patients who shared a hospital

room, failure to utilize the MAR at the bedside contributed to 7.3% of medication errors. Patients in shared hospital rooms were 12.2% more likely to



Clinical alarm safety

Alarms that should be checked frequently for functionality and volume include:

- cardiac alarms
- chair alarms
- bed alarms
- door alarms
- oxygen sensor alarms
- intracranial pressure alarms
- bispectral index monitor alarms
- intra-aortic balloon pump alarms
- core body temperature alarms.

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experience a medication error during their hospital stay.



Goal 6: Reduce the harm associated with clinical alarm systems.

Monitoring clinical alarms is important because of the high risk of patient injury if they’re silenced, turned off, or ignored. All staff members should receive routine education on how to safely utilize the clinical alarms within their work area. All alarms should be checked at the beginning of each shift and periodically in between to ensure that they remain functional and the volume is set at a level loud enough to be heard by healthcare team members. Clinical alarms should never be silenced unless the patient is actively dying, has a completed do-not-resuscitate order, and end-of-life comfort care is the only prescribed treatment.

According to The Joint Commission, 80 patients died and 13 were severely injured in U.S. hospitals between January 2009 and June 2012 as a result of alarm-related problems, including alarms being set improperly, silenced, or inaudible. Consider these strategies to increase clinical alarm safety:

- Closely monitor patients in environments where healthcare teams may be desensitized to alarms because of their frequency linked to nonemergent conditions such as excessive patient movement or patient pulling of ECG leads.
- Check all alarms frequently during your shift to ensure that they remain on, the alarm parameters are correct, and the volume is loud enough to get the attention of all staff members. When clinical alarms are silenced or the parameters are adjusted to prevent activation, it can result in a potentially life-threatening event being ignored and subsequent patient injury or death.

Common patient alarms that should be checked frequently include:

- cardiac alarms, such as ECG, pulmonary artery catheter, heart rate, and BP
- chair alarms
- bed alarms
- door alarms
- oxygen sensor alarms
- intracranial pressure alarms
- bispectral index monitor alarms
- intra-aortic balloon pump alarms
- core body temperature alarms.

Goal 7: Reduce the risk of HAIs.

Despite national attention, the incidence of HAIs remains high. According to the CDC, 1 out of 20 hospitalized patients will contract an HAI. The cost to U.S. hospitals is up to \$33.8 billion annually. These financial costs are tremendous but pale in comparison to the cost in patient safety. To add to this crisis, according to 2013 research, at least 2 million people will be infected with a drug-resistant bacterial infection and 23,000 of those patients will die.

Consider these common interventions to minimize or alleviate the risk of infection:

- Use established guidelines to prevent infection after surgery by administering prophylactic broad-spectrum antibiotics before surgical procedures.
- Receive continuing education on sepsis, including sepsis recognition and the benefits of early goal-directed therapy and treatment protocols.
- Use proven guidelines to prevent catheter-associated urinary tract infections (CAUTIs) by improving indwelling catheter care and decreasing catheter use. It has been estimated that as many as 65% to 70% of CAUTIs may be preventable if evidence-based prevention strategies are applied.
- To prevent central line-associated blood-stream infections, use careful site selection, ensure strict sterility is maintained during the insertion procedure, perform frequent hand hygiene, screen the patient to assess his or her true need for central line placement and use a less invasive access method if possible, identify the maximum length of



did you know?

On December 11, 2013, The Joint Commission released the R3 Report, which states that the clinical alarm NPSG is being implemented in two phases. The first phase went into effect on January 1, 2014, and heightens awareness of the potential risks associated with clinical alarms. The second phase will be effective January 1, 2016, and introduces requirements to mitigate those risks.

The clinical alarm safety goal addresses clinical alarms that can compromise patient safety if they aren't properly managed. This includes alarms on equipment such as cardiac monitors, I.V. machines, and ventilators that have visual and/or auditory components. In general, this doesn't include items such as nurse call systems, alerts from CPOE systems, or other information technology systems.

To read the R3 Report, visit http://www.jointcommission.org/r3_report_explains_new_clinical_alarm_npsg.

time that the catheter can be left in place, and remove the central line as soon as indicated.

- Ensure that evidence-based guidelines or best practices are utilized to reduce the risk of HAIs, such as hand washing, maintaining sterility during dressing changes over invasive lines, and cleansing the oral cavity with chlorhexidine frequently for ventilated patients to reduce the risk of ventilator-associated pneumonia.
- Monitor trends in HAIs. If you note a trend in the same type of infection or culture colonization results, notify infection control personnel so that they can conduct a root cause analysis review to track the source of the transmission. Many healthcare facilities post their infection rate statistics.
- Monitor hand-washing compliance and cleansing of devices routinely used to assess patients such as stethoscopes. All healthcare workers should be regularly educated about the importance of incorporating the CDC hand hygiene guidelines into their daily practice.

The newest hospital NPSG is improving clinical alarm safety.



Goal 15: Identify safety risks inherent in the hospital's patient population.

According to The Joint Commission, patient suicide while in a staffed, around-the-clock care setting is a frequently reported type of sentinel event. It's imperative that healthcare teams identify individuals at risk for suicide while under the care of or following discharge from a healthcare facility. Identifying these patients may require the skills of other healthcare team members, such as psychologists, psychiatrists, and social workers.

Consider these common interventions that you can perform to assist in meeting this goal:

- Ensure that patients who verbalize feelings about or intentions of harming themselves receive an immediate psychiatric evaluation so that the healthcare team can formulate an appropriate care plan.
- Conduct a suicide risk assessment that identifies specific patient characteristics and environmental features or objects that may increase or decrease the risk of suicide.
- Ensure that the patient's immediate safety needs are addressed and work with other healthcare team members to transition the patient to the most appropriate unit, facility, or setting for treatment.
- Ensure that you maintain the patient's privacy and only convey information to family and friends according to your healthcare facility's policy.
- Know how to recognize key indicators that put a patient at risk for suicidal behavior, even in the absence of expressed suicidal ideation. For patients who exhibit risk indicators, conduct and document an assessment of suicidal ideation and plan. Each healthcare organization should have clear policies in place regarding the systematic documentation of suicide risk assessments and interventions that should be completed to optimize patient safety.

Universal protocol: Prevent wrong site, wrong procedure.

The three common elements of the universal protocol for wrong surgery are:

- completing a thorough preoperative verification process
- verifying and marking the operative site with the patient, surgeon, and healthcare team
- taking a formal time out before a procedure to verify that the correct procedure is being performed on the correct site and the correct patient.

The universal protocol should be used in ambulatory care centers, hospitals, critical access hospitals, and office-based settings. When healthcare teams implement and adhere to the protocol, wrong surgery errors that can be attributed to interruptions and distractions can be eliminated.

Consider these Joint Commission recommendations:

- Ensure that the correct surgery is performed on the correct patient and at the correct physical location on the patient's body.
- Mark the correct place on the patient's body where the surgery is to be done.
- Pause before the surgery to ensure that a mistake isn't being made.
- Use time-out practices for all procedures that require mandatory participation.

Between the goal posts!

These goals have been identified by The Joint Commission as the most prevalent issues that can impact patient safety in hospitals. When healthcare teams are dedicated to improving the efficiency of clinical practice, utilizing evidence-based interventions, optimizing system delivery processes, and effectively communicating, they can improve the safety of all patients within their healthcare organization. To read more about the new 2014 NPSGs visit http://www.jointcommission.org/standards_information/npsgs.aspx. ■

Learn more about it

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